

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 hrs. 35 min.

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 14 hrs. 35 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. Route #2 - Spring Lake, Park
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Infant Boy Ankers

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Newborn

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) April 29, 1945 - @ 3:55 p.m.

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

14 hrs. 35 min.9. Birthplace Bethesda, Montgomery, Maryland
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name William Andrew Ankers13. Birthplace Herndon, Virginia14. Maiden name Margaret Elizabeth Hall15. Birthplace Round Hill, Virginia

16. Informant.....

Address

17. CREMATION Date thereof May 1, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory SUBURBAN HOSPITALLocation 8600 Old Georgetown Rd. - Bethesda MD18. Funeral director O. B. Salau, Supt

Address

19. 5/1 45 Wm E Jones
(Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 29, 1945 to April 30, 1945and that I last saw him alive on April 29, 1945

Immediate cause of death.....

Prematurity (5 months)

Due to.....

Due to.....

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address Rockville, Md. Date signed 4/30/45

RECEIVED
MAY 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery CountyCity or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

100 - Westmorland St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County MontgomeryCity or town TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)Street No. 100 - WEST MORLAND ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN HENRY BAILEY

3. (b) Social Security Number

4. Sex

M

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Mary F. Bailey

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

85

hrs. min.

9. Birthplace Montgomery County N. CAROLINA
(Town, county, and state)10. Usual occupation FARMER

11. Industry or business

MOTHER

12. Name JOHN H. BAILEY13. Birthplace N. CAROLINA14. Maiden name CHRISTINE LEEFETT15. Birthplace N. CAROLINA16. Informant FRANK W. BAILEYAddress 524 - W. 31st St. Norfolk, Va17. Burial
(Burial, cremation, or removal. Which?)Date thereof _____
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director W. W. Shanker CoAddress 1400 - Chapin St. N.W.19. April 9 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8 19 45 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/3/45 19 45 to 4/8 19 45and that I last saw him alive on 4/7/45 19 45

Immediate cause of death

Coronary thrombosis

DURATION

Due to

Due to

Other conditions semitic

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE J. L. Markes M.D.

M. D. or other

Address 4601 Seland St Date signed 4/9/45

CERTIFICATE OF DEATH

RECEIVED

APR 24 1945

BUREAU V.S.

Montgomery County

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 223

I. PLACE OF DEATH:

County MontgCity or town Lakona Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County MontgCity or town Lakona Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 801 Garland Ave
(If rural, give LOCATION)2. (a) If veteran, name war World War #1

3. (a) FULL NAME

Leo Gustave Bonnard

3. (b) Social Security Number

092-16-37754. Sex male5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Edna Bonnard

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 29 18958. AGE: Years 49 Months 7 Days 23 If less than one day _____ hrs. _____ min.9. Birthplace New York City
(Town, county, and state)10. Usual occupation electrician11. Industry or business War Production Corp12. Name Leo Bonnard13. Birthplace France14. Maiden name Unknown15. Birthplace Switzerland16. Informant Mrs Edna BonnardAddress 801 Garland Ave. Lakona Park17. Removal Date thereof 4-22-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Washington D.C.18. Funeral director W.W. Chambers &Address 1400 - Chapin St. N.W.19. April-22 1945 Registrar J. W. Doherty
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945, at 1:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1941 to 1945and that I last saw him alive on Sept 1945Immediate cause of death Coronary occlusion

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank J. Broschart M.D.Address Christburg Md Date signed 4-22-45

RECEIVED

APR 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

04036

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Maude Barnes

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 13, 1878

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

667

hrs.

min.

9. Birthplace

Black Creek, N.C.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

matron

FATHER

12. Name

N.C.

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Roger F. Barnes (son)

Address

3914-7th St. N.E. Wash. DC

17. Shipment

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Wilson, N.C.

Location

North Carolina

18. Funeral director

Rev. Reuben Pumphrey

Address

7557 Wis. Ave. Bethesda

19. Date rec'd by registrar

Apr 15 1945N.E. Johnson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Green Echo

(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 Vassar Circle

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 13, 1945 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1944 to April 13, 1945and that I last saw him alive on April 13, 1945Immediate cause of death Respiratory failure

DURATION

Due to

Carcinomatosis

Due to

Cancer of the uterus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Jones M.D.

M. D. or other

Address 8016 Georgetown Rd. Date signed 4/13/45

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

APR 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... MontgomeryCity or town... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C. County...City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 620 Ingraham St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

BORK, Bessie May

3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Ch. Pharn. Frank Bork7. Birth date of deceased (mo., day, yr.) 26 April 1888 6.(c) If alive, give age... years8. AGE: Years 57 Months 0 Days 4 If less than one day... hrs. ... min.9. Birthplace... Texas
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name George Washington Roberts13. Birthplace Indiana14. Maiden name Henry May Barbour15. Birthplace Mississippi16. Informant husband: Frank Robert BorkAddress 620 Ingraham St., N. W., Wash., D.C.17. burial Date thereof 5-2-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director Deal Funeral HomeAddress 4812 Georgia Avenue, N. W.19. April 30 19 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 19 45, at 2:15p. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 April 19 45, to 30 April 19 45, and that I last saw him/her alive on 30 April 19 45.Immediate cause of death Carcinoma of ovary

Due to...

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. R. Reddick M. D. or otherAddress Naval Med. Center Bethesda, Md. Date signed 5-2-45

RECEIVED

MAY 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

CERTIFICATE OF DEATH

04038

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 1/2 days
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County D.C.
 City or town Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5429 Conn. Ave. apt. 304
 (If rural, give LOCATION)
 2.(a) If veteran, name war. ☒

3. (a) FULL NAME

Mrs. Anna K. Brandt.

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married.
 6.(b) Name of husband or wife John Brandt. 6.(c) If alive, give age 76 years
 7. Birth date of deceased (mo., day, yr.) Oct. 27, 1869
 8. AGE: Years 75 Months 5 Days 5 If less than one day
hrs. min.

9. Birthplace Conn.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 FATHER 12. Name Henry Mallenbauer
 13. Birthplace Conn.
 MOTHER 14. Maiden name Mary
 15. Birthplace Codw.

16. Informant Mrs. Thomas Wilkins
 Address 7007 Glendale, Ch. Ch. Md.
 17. Shipment Date thereof 4/2/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Woodlawn Cemetery,
 Location New York City.
 18. Funeral director Wm. Reuben Thompson
 Address 7557 Wis. Ave. Bethesda, Md.
 19. 4-2-45 19 W. S. Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/45 19 45 at 6:55 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
3/20 19 45 to 4/1 19 45
 and that I last saw her alive on 3/31 19 45

Immediate cause of death Cerebral Hemorrhage DURATION 10 1/2 days
 Due to Cerebral arteriosclerosis
 Due to
 Other conditions Hemiplegia
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE Gregory B. Rude M.D. M. D. or other
 Address 3900 Military Rd Date signed 4/2/45

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY

RECEIVED
APR 24 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County 6204 Vorlick La

City or town Glen Echo Montgomery Co. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ethel G Brooks

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife William H

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1879

8. AGE: Years 65 Months Days If less than one day
hrs. min.9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name William F Snider

13. Birthplace Virginia

MOTHER 14. Maiden name Gertrude Caylor

15. Birthplace Virginia

16. Informant William H Brooks

Address 6204 Vorlick La

17. Burial Date thereof 4/23/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location

18. Funeral director The S.H. Hines Co

Address 2901-14th St. N.W.

19. 4/21 1945 Wm E Jones
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Glen Echo
(If outside city or town limits, write RURAL and give nearest town)Street No. 6204 Vorlick La
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1945, at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to April 20 1945
and that I last saw him alive on April 13 1945

Immediate cause of death Chronic nephritis

DURATION

Due to

Due to

Other conditions Rheumatic mitral

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE I. Hammond Mich

M. D. or other

Address 1726 E. N.W. Date signed April 21, 1945

RECEIVED
APR 30 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-51

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

500 Pershing Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montg.City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 500 Pershing Drive
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Mary E. Bryant

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Bert F Bryant

7. Birth date of

deceased (mo., day, yr.) Feb. 5th. 1867.

8. AGE:

Years

78

Months

2

Days

25

If less than one day

hrs. min.

9. Birthplace Schneetady, N.Y.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name JAMES A FURBECK.13. Birthplace New York.14. Maiden name MARY M. BRADT.15. Birthplace New York.16. Informant MRS JAMES B SHUTTS (daughter)Address 500 Pershing Drive17. Removal.

(Burial, cremation, or removal. Which?)

Date thereof APRIL 30, 1945
(month) (day) (year)

Cemetery or crematory

Location PELACIOS, MATAGORDA Co. TEXAS.18. Funeral director Ward & Humphrey.Address 8434 Ga Ave - Silver Spring, Md.19. April 30 19 45 Josephine M. Elchelt
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 19 45 at 2:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 2 19 45 to April 30 19 45and that I last saw him alive on April 24 19 45

Immediate cause of death

Cerebral hemorrhage

DURATION

2 daysDue to Cardio-vascularDue to with hypertension.Seven yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Lynwood Heiges M.D.

M.D. or other

Address 2940 BINEY BRANCH ROAD, N. W.Date signed 4/30/45

WASHINGTON, D. C.

RECEIVED
MAY 3 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1865

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County... Montgomery
City or town... Beltsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since April 15-43.
Hospital, institution, or street address where death occurred... Cedarcroft Sanitarium
How long in hospital or institution? Since April 15-43

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... MD County...
City or town... Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No... 1536 - Monroe St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war... ✓

3. (a) FULL NAME

Martha Wearing Busby

3. (b) Social Security Number

4. Sex F 5. Color of race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife... 8.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 68 Months Days It less than one day hrs. min.

9. Birthplace Marshall, W. Va.
(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name... Martha Wearing

13. Birthplace Marshall, W. Va.

14. Maiden name... Cartwright

15. Birthplace Unknown

16. Informant... Mrs. Ruth Witt

Address 387 - Dane Ave Marion, Ohio

17. Burial Date thereof May 2, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rock Creek Cemetery

Location Washington D.C.

18. Funeral director... Martin W. Hyson Co.

Address 1300 - N. St. N.W. Washington, D.C.

19. apr 29 19 45 Josephine M. Schaeff
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 29 19 45 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 45 to April 29 19 45 and that I last saw him alive on April 29 19 45

Immediate cause of death... Pneumonia, later, terminal DURATION 1 day
Due to... fracture, right hip 2 days
Due to... depressive type of senile psychosis 4 yrs.
Other conditions

(Include pregnancy within 8 months of death)
Major findings of operations... fracture of rt. hip. Date of op. April 12-45

Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... accident Date of April 8-45
Where did injury occur? Montgomery Co. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Cedarcroft Sanitarium
Means of injury Fall Injured at work? No

23. SIGNATURE... J. W. Mitchell M.D.
Address... Silver Spring, Md. Date signed April 29, 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

RECEIVED
MAY 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04042

218

1. PLACE OF DEATH:

County Montgo
 City or town Brooksville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Montgo
 City or town Raytownville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Shirley Marie Carter

3.(b) Social Security Number

4. Sex

female

5. Color or race

colored

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Dec 7, 1945
4 months 1 day

8. AGE:

Years

Months

Days

If less than one day

41

hrs.

min.

9. Birthplace

Brookgrove Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr 8 19 45 at 5.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 15 19 45 to Apr 7 19 45
 and that I last saw him alive on Apr 7 19 45

Immediate cause of death

Brain infarction

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed Apr 8, 1945

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED
MAY 1 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04043

Reg. Dist. No. 218

1. PLACE OF DEATH:

County..... Montg Co.,
 City or town..... Washington Grove Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 8 Mo
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Md..... County..... Montg.,
 City or town..... Washington Grove,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Edith P Case

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Wid ow

6. (b) Name of husband or wife

John W Case

7. Birth date of
deceased (mo., day, yr.)

July 29th 1869

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

1869 75

8

5

.....hrs.min.

9. Birthplace

Green Co., Va.

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

FATHER

12. Name

Edward McMullan

13. Birthplace

Va,

MOTHER

14. Maiden name

Frances Piper

15. Birthplace

Va,

16. Informant

Mrs. Geo. Stringfellow

Address

Wakefield Va,

17.

Burial

4/4/45

(Burial, cremation, or removal. Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory

Standardville Cemetery

Location

Near Standardville Va,

Brickert & Miller

18. Funeral director

Standardville. Va,

Address

19.

April 3 1945

Abrams & Cooke

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 2nd 1945 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov - 25 1944 to April - 2 1945

and that I last saw him alive on Nov - 27 - 1944

Immediate cause of death

Myocardial insufficiency
Arteriosclerosis

DURATION

5 mo

5 mo

Due to

High arterial tension

5 yrs

Due to

Chronic interstitial nephritis

5 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE

H. C. Miller, M.D.
Guthrieburg, Md.
Date signed 4/3/45

RECEIVED
APR 21 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-24)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5600 Edgemoor Lane
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Harry W. Chadduck

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ada B Chadduck
7. Birth date of deceased (mo., day, yr.) June 22, 1873 6. (c) If alive, give age 67 years

8. AGE: Years 71 Months 9 Days 13 If less than one day
.....hrs.min.

9. Birthplace Crawfordsville, Indiana
(Town, county, and state)

10. Usual occupation Banker

11. Industry or business

FATHER 12. Name Charles Chadduck

13. Birthplace Virginia

MOTHER 14. Maiden name Frances Webster

15. Birthplace Virginia

16. Informant Harry Chadduck, Jr.

Address 4820 Bradley Blvd.

17. Removal Date thereof 4/4/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Stiffines Co

Address 2901-14 St NW

19. 4/4 18 45 Am 5:00 PM
(Date rec'd by registrar) (Time)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945 at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 1945 to April 4 1945 and that I last saw him alive on April 3 1945

Immediate cause of death Melanotic carcinoma with DURATION 4 months

secondary meningioma

Due to Cancer of large bowel 1 year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of large bowel

resected about 8 months ago Date of op. April 15, 45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Benjamin M.D. M. D. or other

Address Bethesda Md Date signed 4/4/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 23 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B34

04045

CERTIFICATE OF DEATH

Reg. Dist. No. 916

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 1/2 yrs.
 Hospital, institution, or street address where death occurred:
4534 Middleton La.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Montgomery
 City or town Bethesda Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4534 Middleton La.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Reuben H. Chambers.

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Pauline B.

7. Birth date of deceased (mo., day, yr.)

Mar. 11, 1892

6. (c) If alive, give age

44 years

8. AGE:

Years

53

Months

1

Days

4

If less than one day

hrs.min.

9. Birthplace

Kentucky
(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

FATHER

12. Name

Chas. Wm Chambers

13. Birthplace

Indiana

14. Maiden name

Lillian Hemingway

15. Birthplace

Kansas

16. Informant

Pauline B. Chambers

Address

4534 Middleton La.

17.

Shipment
(Burial, cremation, or removal, Which?)

Date thereof

4/15/45
(month) (day) (year)

Cemetery or crematory

Oak Wood Cemetery

Location

Richmond, Va.

18. Funeral director

Wm Reuben Humphrey

Address

7557 Wis. Ave. Bethesda

19.

4/14
(Date rec'd by registrar)

19

45W.E. Johnson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14/45 19 45 at 7 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 13 19 45 to Apr. 18 19 45and that I last saw him alive on Apr. 13 19 45

Immediate cause of death

Cerebral embolism

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. J. Bauerfeldt
Address Bethesda, Md. Date signed 4/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472 N

04046

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda, (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 days
 Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... South Carolina County...
 City or town... Clinton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 17 Centennial Street,
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war...

3. (a) FULL NAME

CHANDLER, James Austin V. B. P.

3. (b) Social Security Number

4. Sex... W-US 5. Color or race... W-US 6.(a) Single, married, widowed, or divorced... Married

6.(b) Name of husband or wife... Mrs. Julia C. Chandler

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) 2-19-93

8. AGE: Years... 52 Months... 1 Days... 20 If less than one day... hrs. min.

9. Birthplace... South Carolina
(Town, county, and state)10. Usual occupation... retired from service

11. Industry or business

12. Name... James C. Chandler13. Birthplace... South Carolina14. Maiden name... Agnes Austin15. Birthplace... South Carolina16. Informant... Wife: Mrs. Julia C. ChandlerAddress... 17 Centennial St., Clinton, S. C.17. Removal... 4-8-45

(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory...

Location... Clinton, S. C.18. Funeral director... W. W. ChambersAddress... George town, St., Washington, D.C.19. April 8 1945 May 1945

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 1945 19... at 0925 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 Feb. 1945, to 8 April 1945and that I last saw him alive on 7 April 1945Immediate cause of death... Carcinoma (Squamous)Bronchus (Right)Due to... Arterio-sclerosisDue to... Myocarditis, Chronic

Other conditions...

Other conditions...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Carcinoma, Bronchus Rt.Date of op. 4 April 1945Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... E. M. KentE. M. KENT, Lt. Comdr. (MC) USNRAddress... USNH Bethesda, Md. Date signed... 4-8-45

DURATION

unknownunknownunknown

RECEIVED
MAY 2 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
year of birth of deceased
is shown on
FILM NO. G 95 JUN 5 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 782

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County MONTGOMERY
City or town BETHESDA
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

HARRY KING CORNWELL

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife DOROTHEA PAGE

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) OCT 10 / 1887 18868. AGE: Years 58 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace NEW YORK STATE
(Town, county, and state)10. Usual occupation RETIRED

11. Industry or business

12. Name SAMUEL G. CORNWELL13. Birthplace CHATHAM N.Y.14. Maiden name SARA MARSH15. Birthplace KANAWAY NJ16. Informant ALICE H CORNWELLAddress 1919 25TH NW. WASHINGTON17. Burial Date thereof 4/10/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory NEW YORK STATELocation NEW YORK STATE18. Funeral director Joseph Gawlus SonsAddress 1756 - Pa. Ave NW19. 4/4 19 45 Am E Jones
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MONT
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5000 - EDGEMOOR LANE
(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 19 45 at 8:49 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 19 41, to April 4 19 45
and that I last saw him alive on April 3 19 45

Immediate cause of death

Coronary heart failure

DURATION

2 days

Due to

Arterio sclerosis
Hypertension10 years
10 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Subint B. Rude

M. D. or other

Address 3900 Military Rd N Date signed 4/5/45

RECEIVED

APR 24 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date of deceased &
age is shown on
FILM NO. G 95 JUN 1 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 04048 223

1. PLACE OF DEATH: MONTGOMERY
County.....
City or town TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
Solliffe Rest Home
How long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State DC County.....
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5911 - 31st Place NW
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

LAURA

3.(b) Social Security Number

COX

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced W.
6.(b) Name of husband or wife.....
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) Nov 18 1866 1865
8. AGE: Years 78 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace Penn.
(Town, county, and state)10. Usual occupation Retired11. Industry or business Retired12. Name David E. Cox13. Birthplace Penn.14. Maiden name Hannah K. Cox15. Birthplace Penn.18. Informant Maynard EngelmanAddress 470 Cardwell Place17. Final Date thereof April 16, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Columbia NationalLocation Purcell18. Funeral director Frank Lawless SonAddress 1756 Pa. Ave. NW19. April 13 1945 J.D. Duden

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 13 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Apr 28 1945 to Apr 13 1945and that I last saw him W alive on Apr 13 1945

Immediate cause of death.....

Arterial hypertension 2 yrsCardiac decompensation 1 weekDue to Arteriosclerosis

Other conditions.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

RECEIVED

APR 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda - Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 25 days

3. (a) FULL NAME

Walter Cross

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Rockville
 (If outside city or town limits, write RURAL and give nearest town)Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Separated

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb. 2-1869

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

76-219

hrs.

min.

9. Birthplace

Virginia
 (Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Thomas Cross

13. Birthplace

Va.

14. Maiden name

Brooks

15. Birthplace

Va.

16. Informant

Hospital Record

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 23, 1945
 (month) (day) (year)

Cemetery or crematory

Union Wesley

Location

Polomas road

18. Funeral director

Robert S. Brown

Address

246 N. Wash. St Rockville

19.

(Date rec'd by registrar)

19

4/2545Wm E. J. M. D.4/2545Wm E. J. M. D.4/2545Wm E. J. M. D.4/2545Wm E. J. M. D.4/2545Wm E. J. M. D.4/2545Wm E. J. M. D.4/2545Wm E. J. M. D.4/2545Wm E. J. M. D.4/2545Wm E. J. M. D.4/2545Wm E. J. M. D.4/2545Wm E. J. M. D.4/2545

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 21 19 45 at 9:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 27 19 45 to April 21 19 45and that I last saw him alive on April 21 19 45Immediate cause of death... Renal decompensation
(uremia)

DURATION

1 wk.Due to... Urinary tract infection
secondary to bladder paralysisDue to... Transverse myelitis
of spinal cordOther conditions... Syphilis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Wm E. J. M. D.Address... 1736 Eye St. N. W. Washington D. C.Date signed... 4/25/45

RECEIVED
APR 30 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? one month and eight days
 Hospital, institution, or street address where death occurred:
Washington Sanatorium and Hospital
 How long in hospital or institution? one month and eight days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring R.R. #2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.R. #2
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Gladys L Driescher

3. (b) Social Security Number

4. Sex Fe 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife John L Driescher6. (c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) May 24, 1900

8. AGE: Years 44 Months 10 Days 29 If less than one day
 hrs. min.

9. Birthplace New York City, New York
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name ANDREW KING13. Birthplace N.Y.14. Maiden name LAURA HALL15. Birthplace NEW YORK16. Informant Washington Sanatorium & Hospital RecordAddress Takoma Park, Maryland17. Removal Date thereof Apr 23 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EVERGREENLocation BROOKLYN, N.Y.18. Funeral director WARNER F PUMPHREYAddress 8404 GA AVE. SILVER SPRING MD19. 4/23 1945 J. H. H. H. H.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 1945 to Mar 22 1945
 and that I last saw him alive on April 22 1945

Immediate cause of death left heart failure DURATION 2 mo.

Due to Subacute Bacterial Endocarditis 4 mo.

Due to

Other condition Rheumatic Heart Disease 25 yrs.
2 Mitral Stenosis
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op. Vegetative endocarditis

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Marion L Driescher M.D.
M. D. or cert45 Carroll Ave Date signed 22 Apr 45Takoma Park, Md.

RECEIVED

APR 24 1945

BUREAU V.S.

RECEIVED

APR 24 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

04052

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County.....Montgomery
 City or town.....Bethesda (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....45 Minutes
 Hospital, institution, or street address where death occurred:
USNH Bethesda, Md.
 How long in hospital or institution?.....45 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Dist. Of Columbia County.....
 City or town.....Anacostia, D. C. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....7805 Fort Foot
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....☒

3. (a) FULL NAME

John Yates ELKINTON, CCS USN Ret. Inact.

3. (b) Social Security Number

4. Sex.....male
 5. Color or race.....White
 6. (a) Single, married, widowed, or divorced.....Married
 6. (b) Name of husband or wife.....Sussan Elkinton
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....Jan 13 1891
 8. AGE: Years.....54 Months.....2 Days.....18
 If less than one day..... hrs. min.

9. Birthplace.....Delaware
 (Town, county, and state)
 10. Usual occupation.....U. S. Navy
 11. Industry or business.....Retired
 FATHER
 12. Name.....Dave ELKINTON
 13. Birthplace.....Del.
 MOTHER
 14. Maiden name.....Heddie ROBINSON
 15. Birthplace.....Del.

16. Informant.....Wife: Mrs. Sussan Elkinton
 Address.....7805 Fort Foot, Anacostia, Wash., D.C.
 17. burial
 (Burial, cremation, or removal. Which?) Date thereof.....4-1-15
 (month) (day) (year)
 Cemetery or crematory.....Arlington National
 Location.....Arlington, Va.

18. Funeral director.....W. W. CHAMBERS
 Address.....517 11th St., S. E., Wash., D.C.
4-2-15
 19. (Date rec'd by registrar).....may Charlotte Smith
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....April 1 1945 at 6:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep. med. Exam. 19..... to 19.....
 and that I last saw h..... alive on 19.....

Immediate cause of death.....Crown aneurism
 DURATION.....3 hrs.

Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....Frank J. Brochard M.D.
Dep. med. Exam. M. D. or other
 Address.....Washington Md. Date signed.....4-1-15

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

MAY 2 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75)

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery Co
 City or town Martinsburg near Dickerson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12.5 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town _____
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sam C. Fairfax

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Dead

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

55

hrs.

min.

9. Birthplace

Poolesville Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Frank Johnson

13. Birthplace

Montg. Maryland

14. Maiden name

Mary Countee

15. Birthplace

Montg. Maryland

16. Informant

Edna H. Dorsey

Address

Dickerson Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 29, 45
(month) (day) (year)

Cemetery or crematory

Martinsburg Md.

Location

Near Dickerson

18. Funeral director

Clarence H Davis

Address

Poolesville Md

19.

(Date rec'd by registrar)

19

4/27/45
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 25 1945 at 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/12 1944 to 4/25 1945and that I last saw h. alive on 4/25 1945

Immediate cause of death

Cardiac Decompensation

Due to

arterio sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Byron D White, M.D.

M. D. or other

Address

Poolesville, MdDate signed 4/26/45

HOUSE OF REPRESENTATIVES

COMMITTEE ON INVESTIGATION

SENATE COMMITTEE ON INVESTIGATION

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED
MAY 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 04054 216

1. PLACE OF DEATH:

County 20 Winston Drive, Montgomery Co.City or town Country Club Village, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County MontgomeryCity or town Country Club Village
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 Winston Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Orrin Harvey Farr

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Fannie Christie

7. Birth date of

deceased (mo., day, yr.)

October 21, 1889

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

55

hrs.

min.

9. Birthplace

Bristol, Vermont

(Town, county, and state)

10. Usual occupation

Secretary

11. Industry or business

Senator Myers of La.

FATHER

12. Name

George W. Farr

13. Birthplace

Lincoln, Vt.

MOTHER

14. Maiden name

Bertha Atkins

15. Birthplace

Lincoln, Vt.

16. Informant

Mrs. Fannie Christie Farr

Address

20 Winston Drive, Columbia Clubremoval

Date thereof

17. (Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Location

Washington, D. C.

18. Funeral director

The S. H. Wines Co

Address

2901 14th St. N.W.

19.

4/18
(Date rec'd by registrar)

19.

467th E. Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1938 1938 to April 18 1945and that I last saw him alive on April 18 1945

Immediate cause of death

Sudden Coronary Occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Russell Eugene M.D. M. D. or otherAddress 1801 E. St. Date signed 4-18-45

UNITED STATES DEPARTMENT OF HEALTH

INVESTIGATION OF DISEASE

RECEIVED
APR 24 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 Easley St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Garrett Fitzgerald

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of ~~husband~~ or wife MARY A.

7. Birth date of deceased (mo., day, yr.)

April 26, 1875

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

69119

hrs.

min.

9. Birthplace Washington, D. C.
(Town, county, and state)10. Usual occupation RETIRED ENGINEER

11. Industry or business

D. C. SCHOOLS

MOTHER FATHER

12. Name

Thomas Fitzgerald

13. Birthplace

Ireland

14. Maiden name

Bridgett Hogan

15. Birthplace

Ireland

16. Informant

Hospital records

Address

17. BURIAL
(Burial, cremation, or removal. Which?)

Date thereof

Mar. 9, 45
(month) (day) (year)

Cemetery or crematory

St Johns

Location

FOREST GLEN - MONTG. CO. MD

18. Funeral director

Warr & Pumphrey

Address

8434 - Ga Ave - Silver Spring Md

19.

4-7-
(Date rec'd by registrar)

19.

Gertrude B. Lawler
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 31 1945 to April 5 1945and that I last saw him alive on April 5 1945Immediate cause of death Acute MyocardialInfarct

DURATION

4 weeks

Due to

Cardiac Failure1 day

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Sandy Spring Md Date signed 4/5/45

RECEIVED
MAY 9 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 9915 Lohain Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name War

3. (a) FULL NAME

Carolyn Louise Flinchum

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (d) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Jan 27 - 1945

8. AGE:

Years

Months

Days

If less than one day

0221

hrs.

min.

9. Birthplace

Wash. Savatanna Md.
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

MOTHER FATHER

12. Name

Ralph L. Flinchum

13. Birthplace

Va

14. Maiden name

Lizeth Skinner

15. Birthplace

Md.

16. Informant

Allen H. Flinchum

Address

3322 - 9th St. N.E. D.C.

17.

(Burial, cremation, or removal, Which?)

Date thereof

4-17-45
(month) (day) (year)

Cemetery or crematory

Arb. Natl. Cemetery

Location

Ar. Meyer - Va

18. Funeral director

Address

WW Chambers Co
Riverdale Md.

19.

(Date rec'd by registrar)

Apr 17 1945 Josephine M. Schaeffer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 15 1945 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 14 1945 (one office visit only)and that I last saw h..... alive on April 14 1945

Immediate cause of death

Broncho-pneumonia

DURATION

24 hrs.

Due to

Acute Bronchitisseveral days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. H. Reiger M.D.

Address

6450 Piney Br. Rd. Wash. D.C.

Date signed

4-15-45
Wash. D.C.

CERTIFICATE OF DEATH

RECEIVED

MAY 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? one month & four days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.How long in hospital or institution? one month & four days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County _____City or town Alexandria
(If outside city or town limits, write RURAL and give nearest town)Street No. 55 Woodmont Road
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

GARRETT, Franklin Bond, Lt. Col. USMC Ret. Inact

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Mrs. Lydia Garrett7. Birth date of deceased (mo., day, yr.) Dec. 6, 1877 6.(c) If alive, give age _____ years8. AGE: Years 67 Months 4 Days 20 If less than one day _____ hrs. _____ min.9. Birthplace La. (Town, county, and state)10. Usual occupation Retired Lieutenant-Colonel11. Industry or business United States Marine Corps12. Name Franklin Garrett13. Birthplace La.14. Maiden name Elizabeth Bond15. Birthplace La.16. Informant Wife: Mrs. Lydia GarrettAddress 55 Woodmont Road, Alexandria, Va.17. Burial Date thereof 1-28-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director S. H. HINES, SAHAddress 2901 14th St., N. W., Wash., D.C.19. April 26 19 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 April 19 45 at 11:40a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 March 19 45, to 27 April 19 45.and that I last saw him alive on 27 April 19 45.Immediate cause of death Coronary Thrombosis DURATION 3 mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results none done Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Calvin O. Tennell, M.D. M. D. or other _____Address U. S. Naval Hospital, Bethesda Date signed 4/26/45

RECEIVED
MAY 4 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 592

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hoop.
 How long in hospital or institution? 23

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Wash DC County...City or town... Wash DC
(If outside city or town limits, write RURAL and give nearest town)Street No. 3327 - Steyresant Place
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

William W Georges

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Wht

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

Feb. 14, 1865

8. AGE:

Years

Months

Days

If less than one day

80114

hrs.

min.

9. Birthplace

Washington DC
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

John W. Georges

13. Birthplace

Germany

MOTHER

14. Maiden name

Germany

15. Birthplace

Germany

16. Informant

Hoop Records

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Removal

Location

The SH. Jones Co

18. Funeral director

Address

2901- 14th St

19.

(Date rec'd by registrar)

4/11945Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1945 at 3:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10 1945 to April 1 1945and that I last saw him alive on April 1 1945

Immediate cause of death

Cardiac Disturbance

DURATION

30 years

Due to

Ischemic Heart Disease1 month

Due to

Generalized Arteriosclerosis6 years

Other conditions

Chronic Arthritis15 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W B Wardrop MD

M. D. or other

Address

943 BoulevardDate signed April 1, 1945

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

RECEIVED
APR 24 1945
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17020

CERTIFICATE OF DEATH

Reg. Dist. No. 04059 218

1. PLACE OF DEATH:

County Montgomery
 City or town Clarksburg Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Indefinitely
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Paul Grimes

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

none

7. Birth date of

deceased (mo., day, yr.)

Sept. 15, 1928

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

17724

hrs.

min.

9. Birthplace

Adams Co. Pa.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

Daniel J. Grimes

13. Birthplace

Springfield, Ill.

14. Maiden name

Married C. Bishop

15. Birthplace

Clarkburg Pa.

16. Informant

Daniel J. Grimes

Address

Clarksburg, Pa.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

4-11-45
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1945

Abner S. Conk

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr 111945 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. med. exam case

and that I last saw him..... alive on..... 19.....

Immediate cause of death

DURATION

Respiratory failure

Due to

fracture of 2nd cervical

Due to

vertebra with trauma of cord (accidental)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

AccidentDate of 4-11-45

Where did injury occur?

Clarksburg Mont Md

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

highway

Means of injury

auto accident

Injured at work?

no

23. SIGNATURE

Frank J. Brorhaat M.D.

M. D. or other

Address

Clarksburg MdDate signed 4-11-45

RECEIVED
APR 21 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 04660 214

1. PLACE OF DEATH:

County MONTGOMERYCity or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

602 DEERFIELD AVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERYCity or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)Street No. 602 DEERFIELD AVE
(If rural, give LOCATION)2. (a) If veteran, name was None

3. (a) FULL NAME

Mary Elizabeth Hammaros

3. (b) Social Security Number

none4. Sex female 5. Color or race White 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Thomas B Hammaros7. Birth date of deceased (mo., day, yr.) April 2nd 1901 6. (c) If alive, give age _____ years8. AGE: Years 44 Months 0 Days 19 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John E. Plummer13. Birthplace Maryland14. Maiden name Coral Taylor15. Birthplace Maryland16. Informant Thomas B HammarosAddress 602 Deerfield Ave. Silver Spring17. Burial Date thereof April 24 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt CalvaryLocation Lothian, A. A. Co. met.18. Funeral director Warner E. PlummerAddress 8134 Ga Ave. Silver Spring19. Apr. 23 1945 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 21 1945 at 8:00 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam to Sept. Med. Exam 1945
and that I last saw him alive on Sept. Med. Exam 1945

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broerhaart M.D. M. D. or otherAddress Sept. Med. Exam Date signed 4-21-45

RECEIVED

MAY 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

CERTIFICATE OF DEATH

04061

216

Reg. Dist. No.

1. PLACE OF DEATH: **Montgomery**
County.....
Bethesda
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... **20 hours**
Hospital, institution, or street address where death occurred:
USNH Bethesda, Maryland
How long in hospital or institution?..... **20 hours**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... **D.C.** County.....
Washington, D. C.
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No..... **109 5th Street, S. E.**
(If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

3.(a) FULL NAME

Leon Chester HARDIN, Sl/c V-6 USNR

3.(b) Social Security Number

4. Sex **Male** 5. Color or race **White** b.(a) Single, married, widowed, or divorced **Married**
6.(b) Name of husband or wife..... **Mrs. Rose Hardin**
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) **19 Dec. 1919**
8. AGE: Years **25** Months **4** Days **10** If less than one day
..... hrs. min.

9. Birthplace..... **Oklahoma**
(Town, county, and state)
10. Usual occupation..... **Navy**

11. Industry or business

12. Name..... **John Hardin**
13. Birthplace..... **Tex ?**
14. Maiden name..... **Edna Hardin (maiden name unknown)**
15. Birthplace..... **Ark.**

16. Informant..... **Wife: Mrs. Rose Hardin**
Address..... **109 5th St., S. E., Wash., D.C.**

17. **removal**..... Date thereof..... **April 30, 1945**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....
Location..... **Dumas, Texas**

18. Funeral director..... **W. W. Chambers P.U.R.E.T.**
Address..... **1400 Chapin Street, N.W.**

19. **April 30 1945**..... **Mary Charlotte Smith**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **April 29**..... 19**45**, at **9:00 P.** M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... **Def. med. exam case**..... 19..... to..... 19.....
and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

Shock
Due to..... **multiple burns of face body & extremities (accidental)**..... **17 hrs.**
Due to..... **red clothing became ignited from lighted cigarette**
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... **Accidental** Date of..... **4-29-45**
Where did injury occur?..... **Wash.**..... **DC**
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... **Home**Means of injury..... **Burns** Injured at work?..... **no**23. SIGNATURE..... **Frank J. Brochard M.D.** M. D. or other

Address..... **Washington, D.C.** Date signed..... **4-30-45**

RECEIVED

MAY 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 1216 Myrtle Ave. Apt. 101
(If rural, give LOCATION)2. (a) If veteran, name war —

3. (a) FULL NAME

James, Mrs. Jessie Brown

3. (b) Social Security Number

4. Sex

Fe

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Noel V. James8. (c) If alive, give age. — years

7. Birth date of

deceased (mo., day, yr.) Oct. 2, 1891

8. AGE:

Years

Months

Days

If less than one day

73522

hrs.

min.

9. Birthplace Le Roy, Illinois
(Town, county, and state)10. Usual occupation Housewife11. Industry or business —

FATHER

12. Name John Tyler Rhulman13. Birthplace Hager's Ferry, W. Va.

MOTHER

14. Maiden name Cornelia Strider Engle15. Birthplace Hager's Ferry, W. Va.16. Informant Washington Sanitarium & Hosp.Address Takoma Park, Maryland17. Burial Date thereof April 29, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hamden CemeteryLocation Hamden, Ohio18. Funeral director Arthur TalbotAddress 254 Carroll St., Takoma Park, D.C.19. April 25, 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1945 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 22, 1945 to April 24, 1945and that I last saw him alive on April 24, 1945

Immediate cause of death

DURATION

Obstructive jaundice 10 wks.

Due to

Probable malignancy

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —

23. SIGNATURE

M. D. or other

Address Silver Spring, Md. Date signed April 24, 1945

RECEIVED
APR 26 1945
BUREAU V.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 120-6

CERTIFICATE OF DEATH

04063

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... MontgomeryCity or town... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? one month & 5 days

Hospital, institution, or street address where death occurred:

U. S. NAVAL HOSPITAL, Bethesda, Md.How long in hospital or institution? one month & five days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Mass. County.....City or town... Boston
(If outside city or town limits, write RURAL and give nearest town)Street No. 10 Elgin St., West Roxbury
(If rural, give LOCATION)2. (a) If veteran, name war..... ☒

3. (a) FULL NAME

JOYCE, Edward Francis, ANM2c USNR

3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

27 April 1922

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

221129

.....hrs.min.

9. Birthplace... Boston, Mass.

(Town, county, and state)

10. Usual occupation

Navy

11. Industry or business

Navy

FATHER

12. Name

Peter Joyce

13. Birthplace

Mass.

MOTHER

14. Maiden name

Mary Grant

15. Birthplace

Mass.

16. Informant

Mother: Mrs. Mary JoyceAddress 10 Elgin St., West Roxbury, Mass.

17. removal

(Burial, cremation, or removal. Which?)

Date thereof... 4-26-45

(month) (day) (year)

Cemetery or crematory... New Calvary CemeteryLocation... Forrest Hills, Boston, Mass.

18. Funeral director

W. W. CHAMBERS, C.F.C.Address 1400 Chapin St., N. W., Wash., D.C.

19.

26 April 45

19.

Mary Charlotte Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 APRIL 45 at 950 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 MARCH45to 26 APRIL 45and that I last saw him alive on 26 APRIL 45

Immediate cause of death

CARDIOVASCULAR COLLAPSE

DURATION

4 HoursDue to PARALYTIC ILEUS1 WEEKDue to ULCERATIVE COLITIS ACUTE WITH PERFORATION54 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Alvin B. Haines

M. D. or other

Address 1040 Hop Betts Rd, Bethesda Md. Date signed 26 April 1945

RECEIVED

MAY 2 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04064

223.

Reg. Diat. No.

1. PLACE OF DEATH:

County..... MontgomeryCity or town..... Beltsville Park Ind.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred.....
805 Maple St.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... District of Columbia County.....City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No. 3825 Morrison St.
(If rural, give LOCATION)2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

Bertha S. Kugel

3. (b) Social Security Number

4. Sex..... F.5. Color or race..... W.6. (a) Single, married, widowed, or divorced..... Widowed

6. (b) Name of husband or wife.....

Feb 29, 18527. Birth date of deceased (mo., day, yr.)..... Feb. 29, 18528. AGE: Years..... 93

Months.....

Days.....

If less than one day..... hrs. min.

9. Birthplace..... Rochester, New York
(Town, county, and state)10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Joseph W. Crane13. Birthplace..... Unknown14. Maiden name..... Charity Keinans

15. Birthplace.....

16. Informant..... H. Kenneth Kugel - Son

Address.....

17. Removal Date thereof.....
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director..... S. H. Jones Co.Address..... 2901-14th St. N. W.19. April 9 1945
(Date rec'd by registrar)Registrar..... J. W. Dudley

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Apr. 9 1945 at 3:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 4 1945 to Apr. 9 1945and that I last saw him alive on Apr. 9 1945

Immediate cause of death.....

Arterio-sclerosis

Due to.....

congestive heart failure

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. W. DudleyAddress..... 6911 5th St. N.W.Date signed..... 4/9/45

M. D. or other.....

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED
Mrs Bertha Kugel

RECEIVED

APR 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Cherry Chase
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Montgomery
 City or town Cherry Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6710 Central ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Emma Welch Kitchum

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife George Kitchum7. Birth date of deceased (mo., day, yr.) Dec. 16, 1868 B.(c) If alive, give age years8. AGE: Years 76 Months Days If less than one day hrs. min.9. Birthplace Pa. Co. Ill
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
 12. Name David C. Welch
 13. Birthplace Ill
 14. Maiden name Clementine Robinson
 15. Birthplace Ind.

16. Informant Marian Kitchum
Address 6710 Central ave.17. Burial, cremation, or removal. Which? Burial Date thereof 4/29/45
(month) (day) (year)Cemetery or crematory St. George - GaLocation The St. Anne Co.18. Funeral director The St. Anne Co.Address 2901 - 14th St. NW19. 4/29 19 45 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 19 45, at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 25 19 45, to April 28 19 45
 and that I last saw her alive on April 28 19 45

Immediate cause of death Acute Heart Failure

DURATION

1 dayDue to asthma3 years

Other conditions Infected tooth
extraction
 (Include pregnancy within 3 months of death)

3 day

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gisbert B. Rude M.D.

M. D. or other

Address 3900 military rd Date signed 4/29/45

REPORT TO THE SECRETARY OF THE ARMY

WASHINGTON, D. C. 20315

REPORT TO THE SECRETARY OF THE ARMY

REC
MAY 3 1945
BUREAU 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

04066
Reg. Dist. No. 214

1. PLACE OF DEATH:

County... *Montgomery Co*
 City or town... *Silver Spring Rural*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *Three months*
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Anna Longo

3. (b) Social Security Number

4. Sex

Fe

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Anthony Longo

7. Birth date of deceased (mo., day, yr.)

Feb 13, 1882

8. AGE:

Years

63

Months

2

Days

10

If less than one day

— hrs. *—* min.

9. Birthplace

Italy, close to Naples

10. Usual occupation

in housewife

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

MOTHER

14. Maiden name

Anna Bell

15. Birthplace

Mary Shapiro

16. Informant

Address

John Longo

Address

1338 Red Tail AVE NW

17.

Burial

Date thereof

Apr. 24, 1945

Cemetery or crematory

St. Colum

Location

Highway 101

18. Funeral director

Address

Joe. Saunders

Address

1756 B. AVE. NW. W.C.

19.

Apr. 23

19. 45

Josephine D. Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Md.* County... *Montgomery*
 City or town... *Silver Spring (Rural)*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... *(Rural) "White Oak"*
 (If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH... *Apr. 23* 19. *45* at *5:45 PM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 23 19. *45* to *Apr 23* 19. *45*
 and that I last saw her alive on *Apr 23-45* 19. *45*

Immediate cause of death

Coronary disease of heart

DURATION

1/2 month

Due to

unknown

Due to

Other condition

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John N. Andrews M.D.
 Address... *9601 Coleville Rd*
Silver Spring Md
 Date signed *4-23-45*

M. D. or other

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED
MAY 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

04067

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH: 8712 - Colesville Road County: <u>Montgomery</u> City or town: <u>Silver Spring</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death: <u>-</u> Hospital, institution, or street address where death occurred: <u>-</u> How long in hospital or institution?: <u>-</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: <u>Maryland</u> County: <u>Montgomery</u> City or town: <u>Silver Spring</u> (If outside city or town limits, write RURAL and give nearest town) Street No.: <u>8712 - Colesville Rd. # 308</u> (If rural, give LOCATION) 2(a) If veteran, name war: <u>-</u>			
3. (a) FULL NAME: <u>MARIE LESLIE LYLE</u>				3. (b) Social Security Number: <u>-</u>			
4. Sex: <u>Female</u>		5. Color or race: <u>White</u>		6. (a) Single, married, widowed, or divorced: <u>Married</u>			
6. (b) Name of husband or wife: <u>Cornelius R. Lyle</u>				6. (c) If alive, give age: <u>-</u> years			
7. Birth date of deceased (mo., day, yr.): <u>June 12, 1884</u>							
8. AGE: Years: <u>60</u>		Months: <u>10</u>		Days: <u>12</u>		If less than one day: <u>-</u> hrs. <u>-</u> min.	
9. Birthplace: <u>New York City, New York</u> (Town, county, and state)							
10. Usual occupation: <u>Housewife</u>							
11. Industry or business: <u>-</u>							
FATHER	12. Name: <u>Frederick Brower</u>			13. Birthplace: <u>New Jersey</u>			
	14. Maiden name: <u>Marie M. Steencken</u>			15. Birthplace: <u>Unknown</u>			
16. Informant: <u>Cornelius R. Lyle</u> Address: <u>8712 - Colesville Road, Silver Spg.</u>							
17. Disposition Removal: <u>April 24, 1945</u> (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year) Cemetery or crematory: <u>Bedar Hill Cemetery</u> Location: <u>Washington, D.C.</u>							
18. Funeral director: <u>Martin W. Hyson Co.</u> Address: <u>1300 - N. 80 - N.W., Wash. 15, D.C.</u>							
19. <u>Apr. 24</u> 19 <u>45</u> <u>Josephine M. Schaeffer</u> (Date rec'd by registrar) Registrar				23. SIGNATURE: <u>J. B. Glenn</u> M. D. or other: <u>2015 - Ave. St.</u> Address: <u>-</u> Date signed: <u>4-24-45</u>			

MEDICAL CERTIFICATION

2D. DATE OF DEATH: APRIL 24, 1945 at 3:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1941 to April 24, 1945 and that I last saw him alive on April 23, 1945Immediate cause of death: Cardiac failure, 1 dayDue to: hypertension - cardio-vascularDue to: hemiplegia, 6 mo.Other conditions: Arteriosclerosis? day
(Include pregnancy within 3 months of death)Major findings of operations: -
Date of op. -Autopsy results: -
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

RECEIVED
MAY 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? four months, 17 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.How long in hospital or institution? four months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Nebr. CountyCity or town Omaha
(If outside city or town limits, write RURAL and give nearest town)Street No. 2303 South Taw St.,

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

LYNCH, George Francis, Captain USMCR

3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>W-US</u>	6. (a) Single, married, widowed, or divorced <u>single</u>
-----------------------	---------------------------------	---

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 22 July 1918

8. AGE:	Years	Months	Days	If less than one day
	<u>26</u>	<u>8</u>	<u>19</u>	hrs. min.

9. Birthplace Nebr.
(Town, county, and state)10. Usual occupation Marine Corps

11. Industry or business

12. Name William P. Lynch13. Birthplace Neb.14. Maiden name Mary Rauber15. Birthplace Neb.16. Informant Mother: Mrs. Mary LynchAddress 2303 South Taw St., Omaha, Neb.17. removal Date thereof 4-2-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Omaha, Neb.18. Funeral director W. W. ChambersAddress 1400 Chapin St., N. W., Wash., D.C.19. April 2 19 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 19 45 at 9:50 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
14 November 19 44 to April 1 19 45and that I last saw him alive on 31 March 19 45

Immediate cause of death

adenocarcinoma of stomach

DURATION

Aug. 1944

Due to

Due to

Other conditions

ascites

(Include pregnancy within 3 months of death)

Major findings of operations advanced carcinoma of stomach with ascites Date of op. Dec. 4, 1944

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Michael R. Deddish, M.D., USNR

M. D. or other

Address N. W. M. C. Bethesda Md. Date signed

RECEIVED

MAY 2 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Roseville Pike
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 1/2 months
 Hospital, institution, or street address where death occurred:
Waverly Sanatorium
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Montgomery
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Anna M. Macsherry

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Dr. Clinton W.
 7. Birth date of deceased (mo., day, yr.) Feb. 13, 1859 6. (c) If alive, give age _____ years
 8. AGE: Years 86 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Reading Pa.
 (Town, county, and state)
 10. Usual occupation _____
 11. Industry or business _____

12. Name Frank M. Heester
 13. Birthplace Pa.
 14. Maiden name Ella Lauman
 15. Birthplace Pa.
 16. Informant E. H. Hoogewerf
 Address same
 17. Cremation Date thereof 4/9/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill Cem.
 Location nearby
 18. Funeral director Rev. R. E. Humphreys
 Address 7557 Wes. Ave. Bethesda
 19. 4/9 19. 45 Wm E. Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1945 at 3:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15th 1945 to April 8th 1945 and that I last saw her alive on Apr. 8th 1945
 Immediate cause of death Cerebral hemorrhage
 Due to Arterial hypertension 5 years
Arterio-sclerosis 8 or 10 years
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wheeler D. Huff
 M.D. or other _____

Address Bethesda, Md. Date signed Apr. 9/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 24 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B370

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery Co.City or town Takoma-Pk.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

805 Maple Ave. Takoma Park

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County WashingtonCity or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1217 Gallatin St. NW

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary C. Martin

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife Richard C. MartinJan-4

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-4 -1856

8. AGE: Years Months Days If less than one day

89

hrs. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual occupation H.W.

11. Industry or business

12. Name John M. Kemper13. Birthplace Va.14. Maiden name Adeline Cole15. Birthplace Va.16. Informant Lora MartinAddress 1217-Gallatin St. N.W.17. (Burial, cremation, or removal, Which?) Date thereof 4-28-45

(month) (day) (year)

Cemetery or crematory Washington D.C.Location 4812 - Rev. D.C.18. Funeral director Deer Funeral HomeAddress 4812 - Rev. D.C. NW. Wash. D.C.19. April 28 19 45 John D. Dickey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April-28-45 19 at W

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 24 19 45 to Apr. 28 19 45and that I last saw him alive on Apr. 27 19 45

Immediate cause of death

Regelbral hemorrhageDue to arterio-sclerosisDue to arterio-sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. D. DickeyAddress 5th-&*Cedar StDate signed Apr. 28/45

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DISTRICT COURT

RECEIVED
MAY 3 1948
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4602

CERTIFICATE OF DEATH

04071

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months and 4 days

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 months & 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D. C.

City or town 3000 39th St., N. W.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3000 39th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME

MASON, Mary L.

3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6.(a) Single, married, widowed, or divorced widowed

B.(b) Name of husband or wife John Shea

7. Birth date of deceased (mo., day, yr.) 15 June 1870 6.(c) If alive, give age 74 years

8. AGE: Years 74 Months 9 Days 26 It less than one day hrs. min.

9. Birthplace Conn.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name John Shea

13. Birthplace Mass.

14. Maiden name Johanna Shea (maiden name unknown)

15. Birthplace Mass.

16. Informant son: Captain Robert E. MASON USN

Address 3000 39th St., N.W., Wash., D.C.

17. removal Date thereof 4-10-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Bernard

Location New Haven, Conn.

18. Funeral director J. Joseph Gawler, & Sons

Address 1750 Penna. Avenue, N.W., Wash., D.C.

19. 10 April 19 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 19 45 at 0400 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 December 19 44 to April 10 19 45

and that I last saw her alive on April 9 19 45

Immediate cause of death malnutrition as end result of cancer and partial intestinal obstruction DURATION 4 months

Due to Cancer of the Bowel Duration 8 to 9 months

Due to Cancer

Other conditions Severe Secondary Anemia

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Gordon R. Lantz M. D. or other

Address Nat'l. Med. Center Date signed 4-10-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 2 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 218

04072

1. PLACE OF DEATH:

County... Montg. Co.City or town... Gaithersburg, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs 3 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montg.City or town... Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Maud Arnold McDonald

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

William B McDonald

7. Birth date of deceased (mo., day, yr.)

July 18th 1876

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

187668911

..... hrs.

..... min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

House Wife,

11. Industry or business

FATHER

12. Name

John W. Arnold

13. Birthplace

Md

MOTHER

14. Maiden name

Emma C. Stansbury

15. Birthplace

Md

16. Informant

Methodist Home. H. M. Wilson

Address

Gaithersburg Md,

17.

(Burial, cremation, or removal. Which?)

Date thereof

5/2/45

(month) (day) (year)

Cemetery or crematory

Louden Park Cemetery

Location

Baltimore Md,

18. Funeral director

Ernest C Gartner

Address

Gaithersburg Md,

19.

(Date rec'd by registrar)

April 301945Charles S. Cooke

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 29th 1945, at 6 Pm.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1941 to April 29 1945
and that I last saw him alive on April 29 1945

Immediate cause of death

Chronic glomerular nephritis

DURATION

3 years

Due to

Atherosclerosis

Due to

Other conditions

Hypertension
Atrophic arthritis
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ernest F. Kuhn M.D.

M. D. or Other

Address

Rockville, MdDate signed 4/30/45

RECEIVED
MAY 2 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04073 216
Reg. Dist. No.

1. PLACE OF DEATH:

County... Montgomery
City or town... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?... nine months & 6 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
How long in hospital or institution?... nine months & 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Tenn. County...
City or town... Nashville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2618 Gallatin Road
(If rural, give LOCATION)
2. (a) If veteran, name war... ☒

3. (a) FULL NAME

MORGAN, Henrietta

3. (b) Social Security Number

4. Sex... female 5. Color or race... W-US 6. (a) Single, married, widowed, or divorced... married
6. (b) Name of husband or wife...
7. Birth date of deceased (mo., day, yr.)... 22 March 1917 6. (c) If alive, give age... years
8. AGE: Years... 28 Months... 1 Days... 4 If less than one day... hrs. min.

9. Birthplace... Tenn.
(Town, county, and state)10. Usual occupation... Navy11. Industry or business... NavyFATHER 12. Name... Litton Hickman13. Birthplace... Tenn.MOTHER 14. Maiden name... Henrietta Hill15. Birthplace... Tenn.16. Informant... Mo: Mrs. Henrietta HickmanAddress... 2618 Gallatin Road, Nashville, Tenn.17. removal... Date thereof... 4-26-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Mt. OlivetLocation... Nashville, Tenn.18. Funeral director... W. W. ChambersAddress... 1400 Chapin St., N.W., Wash., D.C.19. 4-26- 45 Mary Charlotte Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 26 April 19... 45 at 8:21 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-26 19... 45 to 4-26 19... 45and that I last saw him... alive on 4-26-45 19... 45

Immediate cause of death...

adenocarcinoma of sigmoid

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Edward L. HiepsAddress... U.S.N.H. Bethesda, Md. Date signed... 4-26-45

M. D. or other

RECEIVED

MAY 2 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 129

CERTIFICATE OF DEATH

Reg. Dist. No. 04074 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
U. S. NAVAL Hospital, Bethesda, Md.
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D. C. County D. C.
 City or town Washington, D. C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3015 Georgia Avenue, N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

MOORE, Lucille Darlene

3. (b) Social Security Number

4. Sex female 5. Color or race colored b.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Charles Henry Moore
 7. Birth date of deceased (mo., day, yr.) 22 November 1923 6.(c) If alive, give age 22 years
 8. AGE: Years 21 Months 6 Days 19 If less than one day hrs. min.

9. Birthplace Washington, D. C.
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name George McCorkle
 13. Birthplace N.C.

MOTHER 14. Maiden name Hazel McCorkle (maiden name unknown)
 15. Birthplace N.C.

16. Informant Mo: Mrs. Hazel McCorkle
 Address 3015 Georgia Avenue, N. W., Wash., D.C.

17. burial Date thereof 11 April 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National Cemetery
Arlington, Va.
 Location

18. Funeral director Jarvis, W. Ernest Jue
 Address 1432 U St N. W., Wash., D.C.

19. 4-11-45 19 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 19 45 at 10:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 April 19 45 to 10 April 19 45
 and that I last saw her alive on 10 April 19 45

Immediate cause of death Septicemia (Streptococcus) DURATION 5 days

Due to Pneumonia 1 week

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

A. W. Robishaw
A. W. ROBISHAW, Lt. Condr. (MC) USNR

23. SIGNATURE M. D. or other
 Address U.S. NAVAL HOSPITAL, Bethesda, Md. Date signed 4-11-45

RECEIVED

MAY 2 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
 City or town Fairland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? From March 23, 1945
 Hospital, institution, or street address where death occurred:
Cedarcroft Sanitarium
 How long in hospital or institution? From March 23, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1714 Corwin Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

EMELIA FREDERIKA NELSON

3. (b) Social Security Number

--

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Alfred Nelson

7. Birth date of

deceased (mo., day, yr.)

July 14, 1866

8. AGE:

Years

Months

Days

If less than one day

78

8

19

hrs. min.

9. Birthplace

Sweden

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

FATHER

12. Name

Carl Person

13. Birthplace

Sweden

MOTHER

14. Maiden name

unknown STINA MARIA SVENSEN

15. Birthplace

Sweden

16. Informant

Dr. A. A. Nelson

Address

1714 Corwin Dr. Silver Spr.

17. removal

(Burial, cremation, or removal. Which?)

Date thereof Apr 5 45
(month) (day) (year)

Cemetery or crematory

ONEATA

Location

DULUTH, MINN. (St Louis Co.)

18. Funeral director

Waller & Pumphrey

Address

8434 Ga Ave - Silver Spring, Md.

19.

Apr 5th 1945
(Date rec'd by registrar)

1945

Josephine M. Schaeffer
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 3 19 45, at 11:14 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 23 19 45, to April 3 19 45and that I last saw her alive on April 3 19 45

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cedarcroft Sanitarium Date signed 4-3-45

RECEIVED
MAY 3 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montg
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 days
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Montg
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9508 Baltimore Dr
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Carrie Newburger

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

8. AGE: 80 Years Months Days If less than one day
 hrs. min.

9. Birthplace Baltimore Md
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Samuel Newburger

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace

16. Informant Maude F. Paul

Address 7832-16th St NW

17. Cremation Date thereof April 10 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Eden Hill Crematory

Location Suitland Prince George Md

18. Funeral director B. Dargatzis & Son

Address 3501-14th St NW

19. April 9th 45 Josephine M. Schaeff
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 8 1945 at 5:50 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dep. med. Exam. Case 19

and that I last saw him alive on 19

Immediate cause of death

Acute Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22- VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brochatt M.D.

Address Washington Md M. D. or other

Date signed 4-8-45

RECEIVED

MAY 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 04677 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6803 Clarendon Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 6803 Clarendon Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John T. Nock

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Fannie L. Nock

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

June 13, 1861

8. AGE:

Years

83

Months

10

Days

13

If less than one day

hrs.

min.

9. Birthplace

Virginia
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Farmer

FATHER

12. Name

Levin Nock

13. Birthplace

Virginia

MOTHER

14. Maiden name

Sarah Floyd

15. Birthplace

Virginia

18. Informant

Ellen Sarah Frederick

Address

6803 Clarendon Rd., Bethesda, Md.17. Shipment + Burial Date thereofApril 27, 1945

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Wachapreague

Location

Wachapreague, Va.

18. Funeral director

Wm. E. Humphrey

Address

Silver Spring, Md.

19.

4/26 19 45
(Date rec'd by registrar)Wm E JonesRegistrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 26 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 24 45 to April 26 45
and that I last saw him alive on April 26 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Hyper tension

Due to

Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. A. A. JonesM. D. anesthes

Address

Bethesda, Md.

Date signed

Apr 26 45

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED
APR 30 1945
BUREAU V.B.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

Village or City

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

Registration Dist. No.

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME

(a) Residence: No.

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than

1 day, hrs.
or min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)

FATHER

13. NAME

14. BIRTHPLACE (city or town)
(State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town)
(State or country)17. INFORMANT
(Address)18. BURIAL, CREMATION, OR REMOVAL
Place

Date

19. UNDERTAKER
(Address)

20. FILED

4/7

1945

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

(Month)

(Day)

1945
(Year)

22. I HEREBY CERTIFY That I attended deceased from

I last saw him alive on

to have occurred on the date stated above, at

The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:

Date of onset

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

Reg. Dist. No. 04079 216

1. PLACE OF DEATH:

County Montgomery
 City or town Cabin John
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery
 City or town Cabin John Ward No.
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No. Riverside Ave.
 (If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME

Lilly Ogletree

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed.

6 (b) Name of husband or wife

George Ogletree

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 29, 1852.

8. AGE:

Years

Months

Days

If less than one day

92523

hrs.

min.

9. Birthplace

New York, N. Y.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Mrs. Constance Swenson

Address

Cabin John, Md.

17.

Removal
(Burial, cremation, or removal, Which?)

Date thereof

Apr. 23, 1945
(month) (day) (year)

Cemetery or crematory

Washington D.C.

Location

3072 Nat. Bk.

18. Funeral director

W. W. Chambers Co.

Address

Wash; D.C.

19.

4/23 1945
(Date rec'd by registrar)

19.

Wm E. Jones
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 2219 45 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 41 to April 19 45
 and that I last saw him alive on April 20 19 45

Immediate cause of death

Crown Aneurysm
Anteriorly on the Heart
Coronary

DURATION

15 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Leola Swenson
M. D. or other

Address

2016 Gough St

Date signed

4/24/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 30 1945
BUREAU OF THE U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04080

216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

117 West Glenbrook Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 117 West Glenbrook Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Nicholas Dorsey Offutt

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Bernie Bohrer

7. Birth date of

deceased (mo., day, yr.)

Nov. 18, 18886.(c) If alive, give age 62 years

8. AGE:

Years

Months

Days

If less than one day

57

hrs. min.

9. Birthplace

Rockville, Md.
(Town, county, and state)

10. Usual occupation

Stock Room Clerk C.T.C.

11. Industry or business

MOTHER FATHER

12. Name

Nicholas Dorsey Offutt

13. Birthplace

Montgomery Co., Md.

14. Maiden name

Elizabeth Hulings

15. Birthplace

Ford, Wash., D.C.

16. Informant

Ellen R. Ferris

Address

Sister

17.

(Burial, cremation, or removal, Which?)

Date thereof

4/25/45
(month) (day) (year)

Cemetery or crematory

Rockville Union Cem.

Location

Rockville, Md.

18. Funeral director

Wm. Reuben Humphrey

Address

7557 Wis. Ave. Bethesda

19.

4/24
(Date rec'd by registrar)

19

45Md. E. J. ...

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 2219 45 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 45 to April 19 45and that I last saw him alive on April 22 19 45

Immediate cause of death

Cerebral Thrombosis

DURATION

Acute

Due to

Hypertension & Heart Disease10 yrs.

Due to

Other conditions

.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Dr. J. ...

M. D. or other

Address

1016 ...Date signed 4/23/45

RECEIVED

APR 30 1945

BUREAU

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

04081

1. PLACE OF DEATH

County MontgomeryRegistration Dist. No. 213Village or City RockvilleNo. 500 W. Montgomery Ave. St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 3 yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

Mrs. Adelaide Ord

If U. S. Veteran, specify WAR _____

(a) Residence: No. Route #1, Alexandria, Va.

St. _____ Ward _____

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)Widowed5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofWilliam D. Ord

6. DATE OF BIRTH (month, day, and year)

April 26 - 1864

7. AGE

Years

80

Months

11

Days

16If LESS than
1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.Housewife9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Data deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)Pennsylvania

FATHER

13. NAME

William Sharpe14. BIRTHPLACE (city or town)
(State or country)Penn.

MOTHER

15. MAIDEN NAME

Unknown West16. BIRTHPLACE (city or town)
(State or country)Penna.17. INFORMANT
(Address)Wm. D. Ord II - nephew
906 - Indebury Dr. - Alexandria - Va.

18. BURIAL, CREMATION, OR REMOVAL

Place Philadelphia Pa. Date April 12, 194519. UNDERTAKER
(Address)Wm. Leubus Humphrey
Rockville - Maryland

20. FILED

4/11/45

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

April

(Month)

11

(Day)

1945

(Year)

22. I HEREBY CERTIFY, That I attended deceased from
March 14, 1942, to April 11, 1945.I last saw her alive on April 11th, 1945; death is saidto have occurred on the date stated above, at 7:05a.m.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Thrombosis, cerebralArteriosclerosis, generalArteriosclerosis, cerebral

Date of onset

4/11/45Indefinite1940

Other Contributory Causes of importance:

Psychosis, cerebral arterio-
sclerosis1940Fracture of hip - 3/29/45Name of operation Due to an accidental fall Date of _____What test confirmed diagnosis? autops Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Accident Date of injury March 29, 1945

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury Accidental fall

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed)

Kouglas Noble

M. D.

(Address)

500 W. Montgomery Ave

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthma, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Chronic interstitial nephritis

Cerebral hemorrhage

Date of onset

1915

1921

July 5, 1927

Other contributory causes of importance:

Gallstones

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Run over by street car

Peritonitis

Date of onset

1 week ago

1 week ago

3 days ago

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04082

CERTIFICATE OF DEATH

Reg. Dist. No. 216

FILM No. G 95 JUN 16 1945

1. PLACE OF DEATH:

County... Montgomery
City or town... Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 4-10-45 @ 9:00 a.m. - 4/11/45

3. (a) FULL NAME

Mrs. Marie G. Perry

3. (b) Social Security Number

4. Sex

+

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

—

6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.)

May 20 - 1875

8. AGE:

Years 70

Months 09

Days 11

If less than one day

hrs. — min. —

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

—

12. Name

Claudia Gordon

13. Birthplace

Virginia

MOTHER FATHER

14. Maiden name

Hardy

15. Birthplace

Virginia

16. Informant

Mr. Harry Johnson (Daughter)

Address

412 Shepherd St. Chevy Chase, Md.

17. Removal

Removal

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

—

Location

W.W. Hamberg Co.

18. Funeral director

1400 Chapin St. N.W. Wash. D.C.

19. 4/11 19 45 Wm E. Jones

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 680 Longtown Road
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 45 at 5:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 10 19 45 to April 11 19 45
and that I last saw him alive on April 11 19 45

Immediate cause of death Coronary occlusion
& myocardial infarction

DURATION

24 hours

Due to arteriosclerotic heart disease

Due to hypertensive disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. —

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

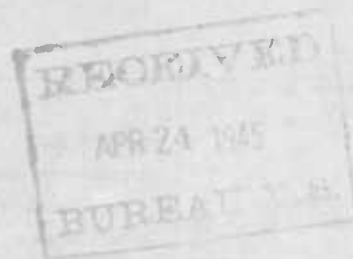
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward J. Stieglitz M.D. or other

1726 Eye St. N.W. Date signed 4/11/45

Address Washington 6



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County MontgomeryCity or town Damascus and
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Damascus
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William E. Piquette

3. (b) Social Security Number

2

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married8. (b) Name of husband or wife Marie Beall PiquetteG. (c) If alive, give age 27 years

7. Birth date of

deceased (mo., day, yr.)

January 9, 1904

8. AGE:

Years

Months

Days

If less than one day

4132

hrs.

min.

9. Birthplace

Damascus Montg and
(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

Store

MOTHER FATHER

12. Name

Orice Piquette

13. Birthplace

Baltimore County

14. Maiden name

Annie Dawson

15. Birthplace

Frederick County

18. Informant

Mrs. William E. Piquette

Address

Damascus, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 8, 1945
(month) (day) (year)

Cemetery or crematory

Methodist Cem

Location

Damascus, Md.

18. Funeral director

J. B. Beall, Inc.

Address

Damascus, Md.

19.

(Date rec'd by registrar)

April 4, 1945

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1945 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3 1943 to April 3 1945and that I last saw him alive on April 3 1945Immediate cause of death Arteriosclerotic cardio-
vascular disease with hypertrophy
and dilatation of heart.

DURATION

3 yearsDue to Marked scoliosis and hunchback
deformity of the whole body35 years

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

James P. Kern M.D.

M. D. or other

Address

Damascus, Md.Date signed 4/4/45

MAINTAIN STATE OF HEALTH

CHIEF OF HEALTH DEPARTMENT

CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REMARKS

RECEIVED
APR 23 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 225

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs.
 Hospital, institution, or street address where death occurred:
Washington Sanitarium + Hospital
 How long to hospital or institution? 6 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 128 Willow Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Flora S. Plummer

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Mr. Frank Plummer
Deceased 8. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) April 27-1862-
 8. AGE: Years 82 Months 11 Days 12 If less than one day..... hrs. min.

9. Birthplace Jay Center - Indiana
 (Town, county, and state)
 10. Usual occupation Sabbath School Secretary girl
Conf. at S.S.A.
 11. Industry or business Retired
 12. Name John H. Fair
 13. Birthplace Penna.
 14. Maiden name Elizabeth Catherine Fair - Fair
 15. Birthplace Penna.

16. Informant Washington San. Records
 Address Takoma Park, Md.
 17. Burial Date thereof April 10, 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rock Creek Cemetery
 Location Washington, D.C.

18. Funeral director James J. Talley
 Address 254 Cassell St. Takoma Park, D.C.
 19. April 9 1945
 (Date rec'd by registrar) Registrar J. William Dodd

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945, at 3:30 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 to 5 years to..... 19.....
 and that I last saw him alive on April 7 1945
 Immediate cause of death Coronary heart disease and
Cerebral
 Due to Left ventricular hypertrophy 3 mm.
Hypertension Two days
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE Chas H. Hobbs M.D.
 Address 502 Indiana St. N.W. Date signed 4-8-45
Washington, D.C.

64-1441

DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

APR 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1447

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery
 City or town Cedar Grove P.O. Germantown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? four years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Cedar Grove P.O. Germantown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Filmore Nelson Poole

3. (b) Social Security Number

212-143856

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Manuel V Poole
 7. Birth date of deceased (mo., day, yr.) Dec 25 - 1881 6.(c) If alive, give age 50 years
 8. AGE: Years 63 Months 3 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Montgomery Co Md
(Town, county, and state)10. Usual occupation Carpenter11. Industry or business Building12. Name Filmore N Poole13. Birthplace Montgomery Co Md14. Maiden name Margaret T. Watkins15. Birthplace Montgomery Co Md16. Informant Manuel V PooleAddress Germantown Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof April 23, 1945
(month) (day) (year)Cemetery or crematory Baptist CemeteryLocation Montgomery Co Md18. Funeral director Paul W BarberAddress Caltonville Md

19. April 21 1945 - Della W Burdett

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 20 1945 at 12:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 1945and that I last saw him alive on April 19 1945

Immediate cause of death _____

DURATION _____

Due to Hemorrhage _____Due to gun shot wound _____Due to Throat heart (suicide) _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 4-20-45Where did injury occur? Cedar Grove Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank J. Brochart M.D.Address Yarhastburg Md Date signed 4-20-45

RECEIVED

APR 25 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington CountyCity or town Union
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Christian F. Rasmussen

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Minnie K. Rasmussen

7. Birth date of

deceased (mo., day, yr.)

September 25, 1879

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

65615

hrs.

min.

9. Birthplace Denmark
(Town, county, and state)10. Usual occupation Sail maker11. Industry or business Navy Yard

FATHER

12. Name Martin Rasmussen13. Birthplace Denmark14. Maiden name Aileen ?15. Birthplace Denmark16. Informant Hospital RecordsAddress Suburban Hospital17. Cremation Date thereof 4/11/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cem.Location Maryland18. Funeral director Wm. Reuben HumphreyAddress 7557 W. Ave. Bethesda19. 4/11 19. 45 NE. Johns Md.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 19 45 at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/6 19 45 to 4/9 19 45and that I last saw him alive on 4/9 19 45

Immediate cause of death

Aspiration pneumoniaDue to Pneumia due to cerebral thrombosis

Due to

Other conditions Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bruc. Benjamin MD. M. D. or otherAddress Bethesda Md. Date signed 4/9/45

RECEIVED
MAR 16 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
Fairland
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? from March 1, 1945
 Hospital, institution, or street address where death occurred:
Cedarcroft Sanitarium
 How long in hospital or institution? from March 1, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Dist. of Col. County
 City or town Washington D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 215 Emerson St. N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name War

3. (a) FULL NAME

JULIA KEMLER (SWARTZ) REESER

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced
widowed

6.(b) Name of husband or wife Frederick H. Reeser

7. Birth date of deceased (mo., day, yr.) February 23, 1872
 6.(c) If alive, give age _____ years

8. AGE: Years 73 Months 2 Days 6 If less than one day
 _____ hrs. _____ min.

9. Birthplace Missouri, near St. Louis
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Jacob J. Swartz13. Birthplace Platteville Wisconsin14. Maiden name Helen Meier15. Birthplace Platteville Wisconsin16. Informant Miss Alice SwartzAddress 215 Emerson St. N.W. Wash. D.C.

17. Cremation Date thereof April 29, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Int. Rm. Co. -Location Pr. by Co. -18. Funeral director The S.H. Jones CoAddress 2901-14th St NW.

19. Apr. 29 1945 Josephine M. Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 1 - 1945 to April 29 1945
 and that I last saw her alive on April 29 1945

Immediate cause of death Cerebral Thrombosis DURATION 2 days

Due to _____
 Due to _____

Other conditions Cerebral Arteriosclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Richard B. Thibodeau M.D. M. D. Thibodeau
 Address Cedarcroft Sanitarium Date signed 4/29-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1945

BUREAU V F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 4.5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Cherry Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1610 Pickwick Lane
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Almira Richardson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

L. S. Richardson

7. Birth date of deceased (mo., day, yr.)

Aug. 3, 1894

8. AGE: Years 50 Months 8 Days 22 If less than one day

9. Birthplace

New York

10. Usual occupation

Housewife

11. Industry or business

Arthon H. Carpenter

12. Name

New York City

13. Birthplace

Canada

14. Maiden name

L. S. Richardson

15. Birthplace

Address 1610 Pickwick Lane

16. Informant

Removal Date thereof 4/25/45

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address 2901 - 14th St. N.W. Wash. D.C.

4/25 1945 Wm E Jones

19. (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1945 at 5:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/23/1945 to 4/25/1945

and that I last saw him alive on 4/23/45

Immediate cause of death

Coronary occlusion

Due to Cerebral Hemorrhage 3 days

Due to Myocardial Infarction

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

L. G. Martine

Address Date signed

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

RECEIVED
APR 30 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *18a*

04089

CERTIFICATE OF DEATH

Reg. Dist. No. *213*

1. PLACE OF DEATH:

County *Montgomery*
 City or town *Shoppin - R+D #2 Rockwell*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *21 years*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State *Maryland* County *Montgomery*
 City or town *Shoppin - R+D #2 (Rockwell)*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Isabella Rickelts

3. (b) Social Security Number

4. Sex *female* 5. Color of race *White* 6.(a) Single, married, widowed, or divorced *Single*6.(b) Name of husband or wife *none*7. Birth date of deceased (mo., day, yr.) *June 5-1870* 6.(c) If alive, give age _____ years8. AGE: Years *74* Months *10* Days *6* If less than one day _____ hrs. _____ min.9. Birthplace *Maryland*
(Town, county, and state)10. Usual occupation *Land keeper*

11. Industry or business

12. Name *Robert H. Rickelts*13. Birthplace *Maryland*14. Maiden name *Mary E. Nicholson*15. Birthplace *Maryland*16. Informant *Mrs. Amy H. Burroughs*Address *R+D #2 Rockwell - Maryland*17. (Burial, cremation, or removal. Which?) *Burial* Date thereof *April 14/45*
(month) (day) (year)Cemetery or crematory *Rockwell Union Cem*Location *Near Rockwell - Maryland*18. Funeral director *Wm. Bruton Tompkins*Address *Rockwell - Maryland*19. *4/13* *45-Joseph D. Waller*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 11* 19*45* at *6.30P* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 24 19*45* to *April 11* 19*45*and that I last saw him/her alive on *April 11* 19*45*

Immediate cause of death _____ DURATION

Cerebral hemorrhage *12 hrs.*

Due to _____

Due to _____

Other conditions *Fracture right femur 2 1/2 yrs**Due to: Accidental fall. Caused*

(Include pregnancy within 3 months of death)

Fall on ice.

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date *January 24, 1945*

Where did injury occur? _____

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *At home, in back yard*Means of injury *Accidental fall* Injured at work?23. SIGNATURE *Esther F. Kuhn M.D.*

M. D. or other _____

Address *Rockville, Md* Date signed *4/13/45*

RECEIVED
APR 26 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (D46)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State District of Columbia County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3806 Davis Place N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Chester F. Ritt

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ethel W. Ritt

7. Birth date of deceased (mo., day, yr.) May 15, 1908 6. (c) If alive, give age 36 years

8. AGE: Years 36 Months 10 Days 28 If less than one day hrs. min.

9. Birthplace Milwaukee, Wisconsin
 (Town, county, and state)

10. Usual occupation Engineer

11. Industry or business

12. Name Franklin C. Ritt13. Birthplace Milwaukee, Wis.14. Maiden name Lydia Kruck15. Birthplace Milwaukee, Wis.16. Informant Hospital RecordsAddress Cremation

17. (Burial, cremation, or removal. Which?) Cremation Date thereof (month) (day) (year) Cedar Hill Cemetery

Cemetery or crematory Cedar Hill CemeteryLocation 4000 Spirit Road, N.W.18. Funeral director W. S. JonesAddress 1756 Pa. Ave N.W.19. 4-15-45 19. NS Jones

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1945 at 12:48 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1945 to April 13, 1945
 and that I last saw him alive on April 13, 1945

Immediate cause of death

Hemorrhage

DURATION

2 daysDue to Rupture Esophageal Varices2 daysDue to emphosis3 yearsOther conditions psoriasis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results emphosis of liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward M. JonesAddress 1726 E. St. N.W. Washington D.C.Date signed 4/13/45

RECEIVED

APR 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-0

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County... Montgomery
 City or town... Silver Spring, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 28 yrs -
 Hospital, institution, or street address where death occurred:
8616 Piney Branch Rd.
 How long in hospital or institution?... None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Montgomery
 City or town... Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 8616 Piney Branch Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

SCHUTT, ANNE CONSTANT

3. (b) Social Security Number

NONE

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife George Franklin Schutt

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Oct 12 1870

8. AGE: Years 74 Months 6 Days 8 If less than one day
 ...hrs. ...min.

9. Birthplace... Peru, Indiana
(Town, county, and state)10. Usual occupation... Housewife11. Industry or business... Own home12. Name... Meliam Mort Constant13. Birthplace... Ohio14. Maiden name... Helen Shields15. Birthplace... Vincennes, Ind.16. Informant... Mrs. Melia B. B. B.Address... 8616 Piney Branch Rd.17. Burial Date thereof... April 23 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory... Rock Creek CemeteryLocation... Washington, D. C.18. Funeral director... Waxner & HumphreyAddress... Silver Spring, Md.19. Apr. 21st 19 45 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 20 19 45 at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 19 23 to April 20 19 45
 and that I last saw him alive on April 17 19 45

Immediate cause of death... Anginal Pectoris DURATION 10 days
 Due to... Myocarditis 5 years
 Due to... High Blood Pressure, Pectoris 10 years
 Other conditions... Atherosclerosis
 (Include pregnancy within 5 months of death)

Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... J. P. Mitchell, M.D. M. D. or other
 Address... Silver Spring, Md. Date signed... April 25

RECEIVED

MAY 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 226

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7119 Marion St.How long in hospital or institution? -

3. (a) FULL NAME

MARGARET BRUFFEY SEBRELL

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 7119 Marion St.
(If rural, give LOCATION)2. (a) If veteran, name war. -

3. (b) Social Security Number

-

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

William H. Sebrell Jr.6. (c) If alive, give age 43 years

7. Birth date of

deceased (mo., day, yr.)

Nov 17 1907

8. AGE:

Years

Months

Days

If less than one day

378-

hrs.

min.

9. Birthplace

Charlottesville Virginia
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

-

FATHER

12. Name

Geo. L. Bruffey

13. Birthplace

Albamarle Co. Virginia

MOTHER

14. Maiden name

Ida J. Faulkner

15. Birthplace

Albamarle Co. Virginia

16. Informant

Wm. H. Sebrell Jr.

Address

7119 Marion St. Bethesda Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

4/24/45
(month) (day) (year)

Cemetery or crematory

Arlington Tr. North Cem.

Location

Arlington, Va.

18. Funeral director

Wm. Reuben Humphrey

Address

7557 Wio. Ave. Bethesda

19.

4/22 45

19.

45Am E. J. J. J.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21 1945 at 11:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 6 1945 to 4-21 1945and that I last saw him alive on 4-20 1945

Immediate cause of death

Pulmonary + Cardiac failure

DURATION

72 hrs.

Due to

Generalized Carcinomatosis

Due to

(Spleen - pelvis - Rt. Breast + arm)

Due to

Metastatic carcinoma

Other conditions

originally in the L. breast

Other conditions

Pathologic fracture ofRt. Humerus due to metastases.

(Include pregnancy within 3 months of death)

Major findings of operations

Many adenocarcinoma Grade III

L. Breast

Date of op.

1940

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Donald J. Birnbaum

M. D. or other

Address

U.S. Public Health ServiceNat. Inst. HealthDate signed 4-21-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460 ✓

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? five days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? five days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash., D.C. CountyCity or town
(If outside city or town limits, write RURAL and give nearest town)Street No. 3738 Southern Avenue, S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

SIMMONDS, Harold Anthony, CRM USN Ret. Inact.

3. (b) Social Security Number

4. Sex male5. Color or race W-US

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Mrs. Kathryn Simmonds

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 19008. AGE: Years 44 Months 7 Days 9 If less than one day
..... hrs. min.9. Birthplace N.Y.
(Town, county, and state)10. Usual occupation Navy

11. Industry or business

12. Name Joseph Simmonds13. Birthplace N.Y.14. Maiden name Minnie Butler15. Birthplace Mass.16. Informant Wife: Mrs. Kathryn SimmondsAddress 3738 Southern Avenue, S. E.17. burial Date thereof 4-4-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. W. ChambersAddress 517 11th St., S. E., Wash., D.C.19. 2 April 19 45 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 19 45 at 1:15 a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
27 March 19 45 to April 1 19 45and that I last saw him alive on 31 March 19 45

Immediate cause of death

DURATION

Cancer of the Rectum = 2 yrs.metastasis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Cancer of Rectum =regional metastases Date of op.Autopsy results Cancer of Rectum = generalized metastases

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE T. S. Ashburn M. D. or otherAddress USNH Bethesda Md Date signed 4-3-45

RECEIVED
APR 7 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Washington SanitariumHow long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County RockvilleCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. Route #4
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Alma Smith

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

Wh-

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Mr. Le Roy Smith

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Jan. 25, 1887

8. AGE:

Years

Months

Days

If less than one day

57212

_____ hrs.

_____ min.

9. Birthplace

Cardtown, Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

CELESTAN BUCK

13. Birthplace

PENNA.

MOTHER

14. Maiden name

REGINA ROSENSTEEL

15. Birthplace

EMMITTSBURG, MD

16. Informant

Washington Sanitarium Records

Address

Takoma Park, Md.17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

Apr. 9 - 45

Cemetery or crematory

ST JOHN'S

Location

FOREST GLEN MONTG CO. MD

18. Funeral director

W. D. Jones & Pumphrey

Address

8401 Ga Ave - Silver Spring - Md.19. Apr 9 - 45

(Date rec'd by registrar)

19 45[Signature]

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 45, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 4, 19 45, to Apr. 6, 19 45and that I last saw him/her alive on Apr. 6, 19 45

Immediate cause of death

Banti's Disease

DURATION

3 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

SplenomegalyDate of op. 4-6-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul V. Starr, M.D.

M. D. or other

Address Takoma Park, Md.Date signed Apr. 6, '45

RECEIVED

APR 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 04095 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

William

7. Birth date of

deceased (mo., day, yr.)

Nov. 15, 1887

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

57528

hrs.

min.

9. Birthplace

Frederick, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetary or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 12

19

45

at

6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/11/45

19

45

to

4/12

19

45

and that I last saw him alive on

4/12

19

45

Immediate cause of death

Coronary Occlusion

DURATION

Due to

Cerebral Hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. A. Martinez

M. D. or other

Address

7209 Overhill Rd

Date signed

Bethesda

RECEIVED
APR 25 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
year of birth of deceased
is shown on

FILM No. G 95 JUN 8 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 570

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery

City or town Germantown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Germantown
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Jacob Cornelius Snyder

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary Elizabeth Snyder

7. Birth date of deceased (mo., day, yr.) Oct 6 - 1864 1874

8. AGE: Years 70 Months 6 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Germantown Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Jacob F Snyder

13. Birthplace Germany

14. Maiden name Hannah F Richter

15. Birthplace Maryland

16. Informant Mrs J C Snyder

Address Germantown Md

17. Burial Date thereof 4-28-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Keelsville Presbyterian

Location Keelsville Md

19. Funeral director B. H. Hill

Address Barnestown Md

19. April 28 - 19 45 Upton D. Jones
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 45, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1927 to April 26 19 45

and that I last saw him alive on April 25 19 45

Immediate cause of death Myocardial infarct

Chronic thyrotoxicosis DURATION 3 yrs

Due to Carcinoma of bladder 2 yrs

Secondary to

Due to Carcinoma of penis

Amputation of penis in 1937

Other conditions Transplantation of ureters

Secondary involvement of bladder.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Upton D. Jones M.D.

Address Keelsville Md Date signed 4/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Boyle
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

James M. Boper

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widower6. (b) Name of husband or wife ?

7. Birth date of

deceased (mo., day, yr.) 3

B. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

74

hrs.

min.

9. Birthplace md

(Town, county, and state)

10. Usual occupation labor

11. Industry or business

12. Name Elsa Boper13. Birthplace Maryland14. Maiden name Mollie Boper15. Birthplace Maryland16. Informant Alvies BoperAddress Pickering md.17. Burial Date thereof 4/6/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Monrovia CmnLocation Bethesda Md19. Funeral director Wm B WiltonAddress Barnesville Md19. 4/4/45 45 Wm E Jones

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 19 45 at 4:25 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/24 19 45 to 4/3 19 45and that I last saw him alive on 4/3 19 45

Immediate cause of death

Coronary Embolism

DURATION

Due to apoplectic stroke 2 weeks

Due to _____

Other conditions Cerebral arteriosclerosis hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. A. Mathew M. D. or other

Address _____ Date signed _____

RECEIVED

APR 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Dist. of Col. County...City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)Street No. 2920 Brandywine St
 (If rural, give LOCATION)2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Annice Stocker

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife... Lewis O. Stocker (deceased)

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

Dec. 3, 1870

8. AGE:

Years

Months

Days

If less than one day

74315

hrs.

min.

9. Birthplace... Saugus, Essex, Mass.

(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

FATHER

12. Name... Willard Luke Fiske13. Birthplace... Saugus, Mass.

MOTHER

14. Maiden name... Elizabeth Williams15. Birthplace... Saugus, Mass16. Informant... Mrs. H. F. Stimson (daughter)Address... 2920 Brandywine St.17. Removal
 (Burial, cremation, or removal. Which?)Date thereof... 4/18/45
 (month) (day) (year)

Cemetery or crematory...

Location...

18. Funeral director... The S.W. Hines Co

Address...

2901 - 14 St. N.W. Washington, D.C.19. 4/18 19 45
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 18th 19 45 at 6:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 18th 19 45 to April 18th 19 45and that I last saw her alive on April 17th 19 45

Immediate cause of death...

Coronary Occlusion

DURATION

1 hr.

Due to...

Coronary Sclerosis

Due to...

MyocarditisDilated

Other conditions

Atrophic Cirrhosis of LiverAcute Renal Thrombosis

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide... None Date of...Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... Thomas J. Jones M. D. or otherAddress... 3741 Huntington St. D.C. Date signed 4/18/45

RECEIVED

APR 24 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1647

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montg.City or town Cherry Chase Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4706 De Russay Pkwy.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montg.City or town Cherry Chase Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 4706 De Russay Pkwy.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Henry Van Wagner

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Florence A.

7. Birth date of

deceased (mo., day, yr.)

March 18, 19016. (c) If alive, give age 42 years

8. AGE:

Years

Months

Days

If less than one day

4412

hrs.

min.

9. Birthplace Hyde Park - New York
(Town, county, and state)10. Usual occupation Attorney at Law

11. Industry or business

12. Name George van Wagner13. Birthplace Hyde Park, N. Y.14. Maiden name Marah E. Glees15. Birthplace Hyde Park, N. Y.16. Informant Mrs. Florence A. Van WagnerAddress 4706 De Russay Pkwy.17. Burial
(Burial, cremation, or removal. Which?)Date thereof 4/23/45
(month) (day) (year)Cemetery or crematory George Washington MemorialD.C. Md. Cen.Location D.C. Md. Cen.18. Funeral director Wm Reuben HumphreyAddress 7557 Wis. Ave. Bethesda19. 4/27 19. 45 NE. Johns Md.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19. 45 at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death cannot determineuntil pathological reportare completeDue to The only findings were 0.2% alcoholin the brain. We have never determined theDue to exact cause of death. Poison.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Report later

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Poison Date of 2Where did injury occur? Cherry Chase Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) was homeMeans of injury — Injured at work? no23. SIGNATURE Dr. Benoit PoitrelAddress Sandy Spring Md. Date signed 4/21/45

RECEIVED
APR 30 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04100

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, institution, or street address where death occurred:

308 Hancock Ave.How long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 308 Hancock Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Goldsburrrough Benjamin Walker

3. (b) Social Security Number

--

4. Sex

M

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Rebecca E. Walker

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years Months Days If less than one day

79 hrs. min.9. Birthplace Markham, Va.

(Town, county, and state)

10. Usual occupation Janitor11. Industry or business Office Bldg.12. Name --13. Birthplace --14. Maiden name Mary --15. Birthplace --16. Informant Mrs. G.B. WalkerAddress 308 Hancock Ave., Takoma Pk., Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory RemovalLocation Washington, D.C.18. Funeral director Robert G. McGuireAddress 1820 - 9th St., N.W.19. 4/28/45 19 J. Wilson Dodd

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1945 at 6 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1944 to April 1945and that I last saw him alive on April 10, 1945

Immediate cause of death

Cerebral apoplexy DURATION 12 hrs.Due to Arteriosclerosis 5 yrs.Due to Senile degenerationOther conditions --

(Include pregnancy within 8 months of death)

Major findings of operations -- Date of op.Autopsy results --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *** William Y. Spicer M. D. or otherAddress 703 C St., S.W. Date signed April 28, 45Washington, D.C.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. (AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

04101

214

1. PLACE OF DEATH

County Montgomery
 Village or City Silver Spring

Registration Dist. No. 214No. 1015 Dale Drive St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME Mary Clement Watson If U. S. Veteran, specify WAR _____(a) Residence: No. 1015 Dale Drive, Silver Spring, Maryland
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of <u>James Angus Watson</u>		
6. DATE OF BIRTH (month, day, and year) <u>Sept. 1, 1867</u>		
7. AGE Years <u>77</u>	Months <u>7</u>	Days <u>12</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Housewife</u>		
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>Own Home</u>		
10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (city or town) <u>Sunbury</u> (State or country) <u>Pa.</u>		
13. NAME <u>David Clement</u>		
14. BIRTHPLACE (city or town) <u>Sunbury</u> (State or country) <u>Pa.</u>		
15. MAIDEN NAME <u>Sarah Jane Woberton</u>		
16. BIRTHPLACE (city or town) <u>Sunbury</u> (State or country) <u>Pa.</u>		
17. INFORMANT <u>Harold Fraser Watson</u> (Address) <u>9709 Warren St., Linden, Md.</u>		
18. BURIAL, CREMATION, OR REMOVAL Place <u>Rock Creek Cemetery</u> <u>Apr. 16, 1945</u>		
19. UNDERTAKER <u>Warner E. Pumphrey</u> (Address) <u>Silver Spring, Md.</u>		
20. FILED <u>Apr. 15, 1945</u> <u>Josephine M. Schaeffer</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

April (Month) 13 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from

January, 1944, to April 13, 1945—
 I last saw him alive on April 13, 1945; death is said

to have occurred on the date stated above, at 4:45 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Failure
Carcinoma of Stomach

Date of onset
4/3/45
6 months

Other Contributory Causes of importance:

Cholelithiasis2 weeksName of operation Cholecystectomy Date of 4/14/45What test confirmed diagnosis? autopsy X-ray Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) W. B. Warden M. D.(Address) 743 Bonnyard St.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923
------------	-------------

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year
-----------------	--------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
 County... **Montgomery County**
 City or town... **Bethesda (Rural)**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **3 mos. 16 days**
 Hospital, institution, or street address where death occurred:
U.S.N.H. Bethesda, Md.
 How long in hospital or institution? **3 mos. 16 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... **Nebraska** County.....
 City or town... **Omaha**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **2412 Dodge St.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

THOMAS Allfree WEIR

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **US White** 6. (a) Single, married, widowed, or divorced **divorced**
 6. (b) Name of husband or wife **Mrs. Margarie Quivy**
 7. Birth date of deceased (mo., day, yr.) **January 13, 1901** 6. (c) If alive, give age..... years
 8. AGE: Years **44** Months **3** Days **15** If less than one day..... hrs. min.

9. Birthplace **Indiana**
 (Town, county, and state)
 10. Usual occupation **State Department**
 11. Industry or business.....
 12. Name **David Weir**
 13. Birthplace **Indiana**
 14. Maiden name **Ethel Allfree**
 15. Birthplace **Pennsylvania**

16. Informant **Mr. David Weir**
 Address **2412 Dodge St., Omaha, Neb.**
 17. **removal** Date thereof **4-28-45**
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory **Forrest Lawn**
 Location **Omaha, Neb.**
 18. Funeral director **S. H. HINES, J.D.H.**
 Address **2901 14th St., N.W., Wash., D.C.**
 19. **28 April 45** **Mary Charlotte Smith**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... **28 April 1945** at **8:25am**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **10 Jan 1945** to **28 April 1945**
 and that I last saw him alive on **28 April 1945**
 Immediate cause of death **Pneumonia**

Due to **Emphysema**
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results **not done**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE **C. S. Smith** M. D. or other
 Address **US Naval Hospital Bethesda, Md.** Date signed **4-28-45**

RECEIVED

MAY 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 04103 216

1. PLACE OF DEATH:

County Montgomery
 City or town Cherry Chase
 (If outside city or town limits write RURAL and give nearest town)
 How long in above place of death? 4 weeks
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County Montgomery
 City or town Cherry Chase
 (If outside city or town limits write RURAL and give nearest town)
 Street No. 6800-44-14
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Madge Shults Whitmeyer

3. (b) Social Security Number

4. Sex F 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife William Whitmeyer (deceased)7. Birth date of deceased (mo., day, yr.) Apr. 29, 18778. AGE: Years 67 Months 0 Days 0 If less than one day hrs. min.9. Birthplace Springville, Erie, NY
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Chester Shults13. Birthplace Springville NY14. Maiden name De Ida Multer15. Birthplace Ashford NY16. Informant Mrs Irene BaalfieldAddress 6800-44. Ch. Ch. 15MD17. Shipment Date thereof 4/30/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Liberty Park CemeteryLocation Cottontown, N.Y.18. Funeral director Wm. Platen HumphreyAddress 7557 Wis. Ave. Bethesda19. 4/27 19. 45 Wm E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1945 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 19. 45 to Apr 27 19. 45and that I last saw her alive on Apr 26 19. 45Immediate cause of death Coronary Occlusion INSTANTDue to Hypertensive Heart Disease 3 yrs.Due to Arteriosclerosis some

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. O'Donnell M. D. or otherAddress 4307 E. Washington Date signed 4/27/45

RECEIVED
MAY 3 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-2

CERTIFICATE OF DEATH

Reg. Dist. No. 2413

1. PLACE OF DEATH:

County MONTGOMERY
City or town TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 1/2 yrs.

Hospital, institution, or street address where death occurred:
801 Greenwood Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY
City or town TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)

Street No. 801 Greenwood
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

NELIA MARTHA GRIGGS - WOOD

3. (b) Social Security Number

4. Sex FE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED

6.(b) Name of husband or wife ALTHEUS HAMILTON WOOD

6.(c) If alive, give age DECEASED years

7. Birth date of deceased (mo., day, yr.) MAY 15, 1860

8. AGE: Years 84 Months 11 Days 1 If less than one day hrs. min.

9. Birthplace QUASSO, MICHIGAN
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name EXRA GRIGGS

13. Birthplace MICHIGAN

14. Maiden name NOT KNOWN TO INFORMANT

15. Birthplace

16. Informant LYNN H. WOOD

Address 801 GREENWOOD AVE-TAKOMA PARK

17. Burial Date thereof April 24, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory FOREST LAWN MEMORIAL PARK

Location GLENDALE, CALIFORNIA

18. Funeral director James J. Talbot

Address 334 Carroll Dr. N.W. Takoma Park, D.C.

19. April 17, 1945 Registrar J. H. Wood

(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 16 19 45 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 42 to Apr. 16 19 45
and that I last saw her alive on about March 1st 19 45

Immediate cause of death Acute Cardiac Failure DURATION 1 hr.

Due to Arteriosclerotic Heart Disease 5-10 yrs.

Other conditions Generalized Arteriosclerosis
Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Marion J. Browne M.D.

455 Carroll Park - Md. M. D. or other

Date signed 16 Apr 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1945

BUREAU V.S.

(Certificate approved by Dr. Frank J. Broschart
Med. Exams. Montg. Co.)